CAI
HR
- Z027

Human Resources Development Canada
Développement des ressources humaines Canada

Government Publications

Unemployment Insurance

Application guide

Unemployment Insurance Premium Reduction Program

For employers with short-term disability plans

3 1761 11557022 8

Canada

IN-121A-04-95E

© Minister of Supply and Services Canada 1995
Cat. No. LUZ-94/1-1995E
ISBN 0-662-23020-5

For further information on
the Premium Reduction Program,
please contact:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5
Toll free: **1-800-561-7923**
Facsimile: **(506) 548-7473**

Produced by Communications (Insurance)
Human Resources Development Canada

Printed in Canada

Table of contents

Government Publications

1. Application procedure 1

2. Schedules 1

3. Supporting documents 2

4. Application deadline 2

Initial application form 4
Instructions to complete the initial application 7

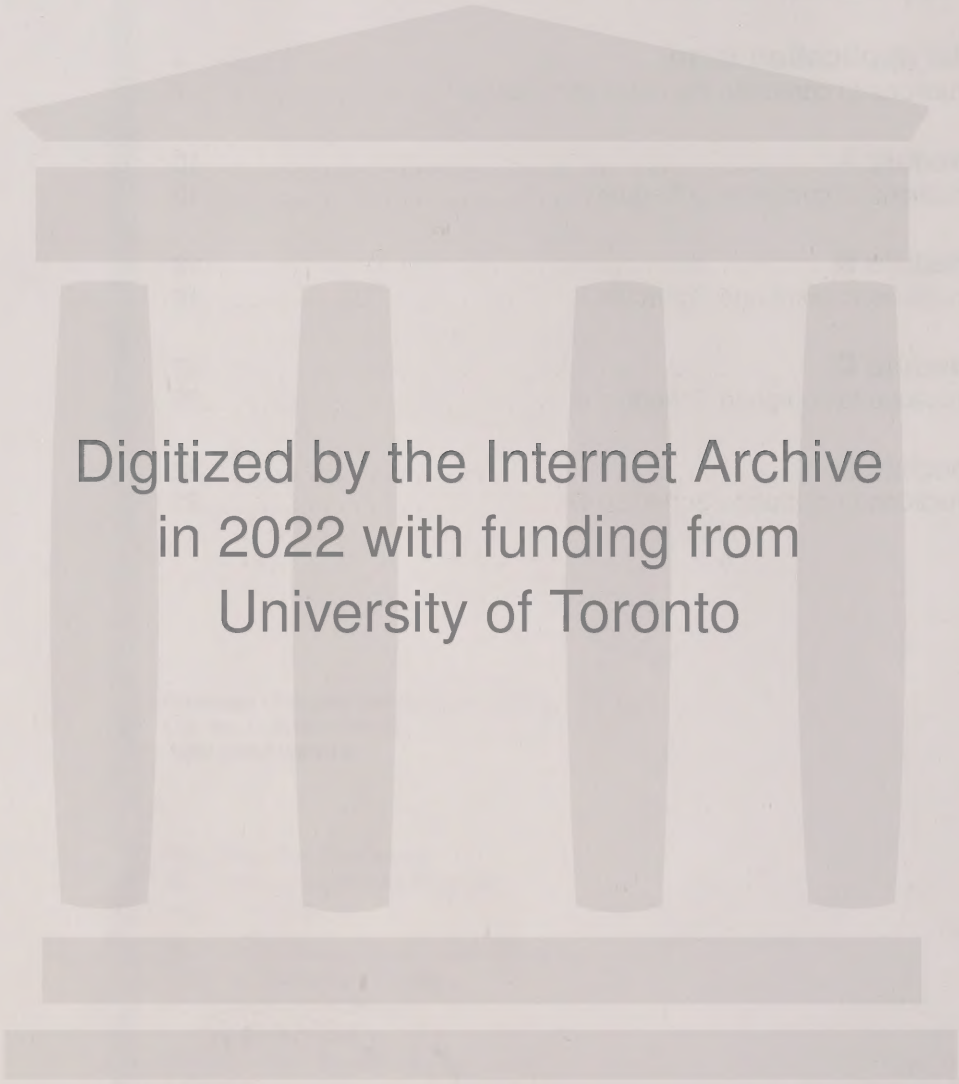
Schedule A 10
Instructions to complete Schedule A 13

Schedule B 16
Instructions to complete Schedule B 19

Schedule C 22
Instructions to complete Schedule C 25

Schedule D 28
Instructions to complete Schedule D 31

LIBRARY
NOV 2
UNIVERSITY OF TORONTO


Digitized by the Internet Archive
in 2022 with funding from
University of Toronto

https://archive.org/details/31761115570228

Initial application for premium reduction

Application procedure

1. How do I apply for a premium rate reduction?

The following pages contain a copy of the initial Application and Schedules along with step-by-step instructions. Please note that you only have to complete the schedules relating to each type of plan you have. In some cases, you may have to complete more than one schedule for the same plan. This would apply if the benefits provided under the plan are different for different groups of employees (e.g., the benefit duration could be 15 weeks for union employees and 26 weeks for office staff).

We suggest that you keep a copy of your Program Guide at hand while completing the application and schedule(s), as some of the instructions will refer you to specific parts of this guide for more detailed information.

If you require assistance to complete these forms, or would like additional copies, please call toll free at: 1-800-561-7923

Forward to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5

Schedules

2. What schedules must I complete?

The type of short-term disability plan you provide will determine which of the following schedules you must complete. For a description of the different types of plans please refer to page 2 of the Program Guide.

Schedule A (page 11)
Complete one copy for each weekly indemnity plan underwritten by an insurance carrier.

Schedule B (page 17)
Complete one copy for each self-insured weekly indemnity plan.

Schedule C (page 23)
Complete one copy for each cumulative paid sick leave plan.

Schedule D (page 29)

Does not refer to any particular plan. One copy of this schedule must be completed for each method of returning the employee's portion of the premium reduction, when no written agreement exists for that group.

Supporting documents

3. What supporting documents are required?

To determine if you meet the conditions for a premium reduction, the Department must receive the following supporting documents with your initial application:

- a copy of your formal commitment (describing your Weekly Indemnity Plan and/or Paid Sick Leave Plan);
- a copy of the respective collective agreement(s) (if your application covers employees who are members of a certified bargaining unit, i.e., unionized employees);
- a copy of the written mutual agreement between you and your employees regarding returning their portion of the reduction, if such an agreement exists (if no such agreement exists, a copy of the completed Schedule D must accompany the application).

The Department may request information to assist in making a decision. You must provide this information within a period of 30 days from the date of request. Any delay will have an impact on the effective date of the reduction.

Application deadline

4. What is the deadline for submitting applications?

There is no deadline for the submission of applications, but the effective date of your reduction will, in part, be based on the date your application was submitted. Therefore, it would be to your advantage to submit your completed application and supporting documents as soon as possible.

Initial application
(Form on page 5)

Steps to follow:

1. Fill out the initial application.
2. Determine which schedule or schedules you need to fill out.
3. You may make photocopies of the form.
4. Fill out a schedule for each plan you intend to register.
5. Keep a copy of the application form and of all the schedules.
6. Forward to:

   Human Resources Development Canada
   Premium Reduction Program
   Nicolas Denys Building
   P.O. Box 11000
   Bathurst, New Brunswick
   E2A 4T5

Human Resources Development Canada | Développement des ressources humaines Canada

INITIAL APPLICATION FOR A UI PREMIUM REDUCTION

1. RC or SBRN

BEFORE COMPLETING SEE INSTRUCTIONS IN GUIDE.

2. a) Legal name of the company

b) Operating name, if different from the legal name

3. Address:

Postal Code

4. Contact Person for payroll purposes

Name (Please Print) ( ) Telephone Number

Title ( ) Fax Number

5. Total number of employees for whom you remit UI premiums under the above RC number or SBRN:

6. Are you remitting UI premiums under the above RC number or SBRN for employees not covered under your short-term disability plan(s)?

☐ Yes ☐ No If yes: - Indicate the number of employees not covered by your plan because they are serving the eligibility period of the plan.
- Indicate the number of employees not covered by your plan for any reason other than the eligibility period.

7. Indicate the method you will be using to return the employees' portion of the premium reduction:

8. Has this method been adopted, or will it be adopted, as a result of a written agreement between you and your employees?

☐ Yes ☐ No IF YES, ATTACH COPY OF AGREEMENT. IF NO, COMPLETE A SCHEDULE "D" FOR **EACH** METHOD AND ATTACH TO YOUR APPLICATION.

9. How many short-term disability plans do you wish to register?

10. Language of communication: ☐ English ☐ French

NOTE: YOU MUST COMPLETE AND INCLUDE A COPY OF THE APPLICABLE SCHEDULE FOR EACH PLAN.

SCHEDULE "A" USED FOR WEEKLY INDEMNITY PLANS UNDERWRITTEN BY AN INSURANCE COMPANY.

SCHEDULE "B" USED FOR SELF INSURED WEEKLY INDEMNITY PLANS. NOTE: ADMINISTRATIVE SERVICES ONLY (ASO) PLANS ARE CONSIDERED SELF-INSURED PLANS.

SCHEDULE "C" USED FOR CUMULATIVE PAID SICK LEAVE PLANS.

DECLARATION

I declare that the information given in this application and supporting schedules is true and is for the purpose of applying for an Unemployment Insurance premium reduction.
I am aware that there are penalties for making false statements.

Signature of Authorized Officer Date

Name (Please Print) Title

NOTE: IF YOU ARE REQUESTING A PREMIUM REDUCTION FOR MORE THAN ONE RC NUMBER OR SBRN, YOU MUST COMPLETE A SEPARATE APPLICATION FORM FOR EACH NUMBER.

FOR OFFICE USE ONLY

File No:	Request Date:	Decision:	Officer:	Date:

Instructions to complete the initial application

The numbers below refer to the item numbers on the application.

1. **Revenue Canada (RC) Number or Single Business Registration Number (SBRN)**
   Enter the RC or the SBRN number under which you remit UI premiums.

   If you wish to apply for a premium reduction for more than one number, a separate application form must be completed for each number (or extension in the case of SBRN's).

2. **Company identification**
   a) Enter the name under which you are legally incorporated;

   b) Enter the name under which the company is doing business, trading or operating (if different from the legal name).

3. **Address**
   Enter the complete mailing address of the company.

4. **Contact person for payroll purposes**
   Enter the name, title, area code and telephone number (extension, if applicable), and facsimile (FAX) number of the person to contact for payroll purposes. This person should be in a position to answer questions regarding employee count, employee groupings, remitting of UI premiums or any other questions relating to payroll.

5. **Number of employees under the RC or SBRN number**
   Indicate the total number of employees for whom you remit UI premiums under the above RC or SBRN number. Include all employees, even those who are not covered by a short-term disability plan.

6. **Employees covered or not covered by your plan**
   If you are remitting UI premiums under the above RC or SBRN number for employees not covered by your plan, answer "Yes". If all the employees for whom you are remitting UI premiums under the above RC or SBRN number are covered by your plan, answer "No". If you answered "yes", provide numbers of employees not covered because they are serving an eligibility period (question #1) and the number of employees not covered for any other reason (question #2). Employees not covered may include: part-time or temporary employees, summer students or employees who do not want to participate in the plan.

7. **Method used to return the employees' portion of the premium reduction**
   (See Program Guide Part I, Item 1.2)

8. **Agreement concerning the method to return the employees' portion of the premium reduction**
   Indicate if you have a written agreement with your employees regarding the method described in answer to question 7 above. If you have a written agreement, please attach a copy to your application. If not, you can either prepare such an agreement with the help of the sample provided in Part I, Item 1.2 of Program Guide, or complete a copy of Schedule D (for each method) and send it with your application.

9. **Total number of short-term disability plans being registered**
   Please indicate the overall number of plans you wish to register with this application. For instance, you could have a weekly indemnity plan underwritten by an insurance company for your hourly employees and a self-insured weekly indemnity plan for your salaried employees. If this were the case, you would have to complete a Schedule A and a Schedule B.

10. **Language of choice**
    Please indicate the language we should use when communicating with you.

The application must be signed by an authorized representative of the company. Please forward it, along with the appropriate schedule(s) and supporting documents *(See Program Guide Part II, Item 1, page 11)* to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5

If you require assistance to complete these forms,
please call toll free: **1-800-561-7923**

Schedule A
(Form on page 11)

Steps to follow:

1. Fill out Schedule A if you have a Weekly Indemnity Plan underwritten by an insurance company.
2. You need to fill out one schedule for every plan you have; you may make photocopies of the form.
3. Attach the completed schedule(s) to the Initial Application Form.
4. Do not forget to keep a copy of the completed form for your files.

Human Resources Development Canada / Développement des ressources humaines Canada

SCHEDULE "A"

WEEKLY INDEMNITY PLAN - UNDERWRITTEN BY AN INSURANCE COMPANY

BEFORE COMPLETING, SEE INSTRUCTIONS IN GUIDE.

1. Employer Name:

2. RC or SBRN

3. a) Name of the Insurance Carrier

b) Group policy number Division # (if applicable)

c) Are you the policyholder? ☐ Yes ☐ No If no, indicate name of policyholder:

d) Effective date of this plan

4. a) Total number of employees covered by this plan

b) Number of non-union employees

c) Number of union employees

d) List union group(s) if applicable:

Name of Union	Local #	Expiry date of Collective Agreement

5. If the plan covers more than one group of employees, are the benefits different for each group?

IF YES, COMPLETE A SEPARATE SCHEDULE "B" FOR EACH GROUP OF EMPLOYEES. Specify the group of employees to which this schedule applies:

☐ Yes ☐ No

6. a) How long must an employee work, from the date of hire, before becoming eligible for benefits?

After completion of _____ (specify: hours, shifts, days or months worked)

b) If the period is expressed in hours, shifts, days, or otherwise, calculate the maximum number of **months** an employee would have to work starting from the date of hire, before being eligible for benefits under this plan:

7. If a separation from employment, for reasons other than illness or injury, occurs while an employee is receiving benefits under your plan, when would payments terminate?

8. Are your employees covered 24 hours a day for any illness or injury?

☐ Yes ☐ No If no, explain

9. If the disability extends beyond the duration of benefits provided by this short-term disability plan, would your employees be covered for benefits under a long-term disability plan?

☐ Yes ☐ No

If yes, what is the reinstatement period for recurring disabilities under this long term plan? _____

10. Contact person for plan information

_____ Name (Please print)

( ) _____ Telephone #

_____ Title

( ) _____ Fax #

NOTE: YOU MUST INCLUDE A COPY OF THE INSURANCE POLICY WITH YOUR APPLICATION

Instructions to complete Schedule A

Weekly Indemnity Plans underwritten by an insurance company

- **You must complete Schedule A** for each Weekly Indemnity Plan underwritten by an insurance company, or for each group of employees if different benefits are provided under the same plan.

1. **Name of the company**
   Enter the name of the company. This will be used to match this schedule to the Initial Application.
2. **RC Number or SBRN**
   Enter the RC number or SBRN to which this schedule applies.
3. **Information on your insurance carrier**
   a) Enter the name of the insurance company who underwrote your insurance policy.
   b) Enter the number of your group policy, and indicate the division number if applicable.
   c) Indicate if you are the policyholder. If not, please enter the name of the company or association who holds the policy.
   d) Indicate the date your plan came into effect.
4. **Number of employees covered by this plan**
   a) Enter the number of employees for whom you remit UI premiums **and who** are covered by this plan.
   b) Indicate how many are non-union.
   c) Indicate how many belong to a union or unions.
   d) List the name of each union group, local number and expiry date of the current collective agreements.
5. **Groups/benefits**
   If more than one group of employees is involved, and you provide different benefits to each group under this plan, answer "yes" and complete a separate Schedule "A" for each group. For instance, the period of benefits could be different for union employees (e.g. 15 weeks) and for office staff (e.g. 26 weeks); or amount of benefits could be 60% for plant workers and 80% for management, etc. Identify the group of employees to which this schedule applies.
6. **Eligibility period**
   a) Indicate the period of time an employee must work before becoming eligible for benefits. This may be expressed in hours, shifts, days, weeks or months worked.

b) If the answer to question 6 a) is already expressed in months, go to question 7. If it is expressed otherwise, calculate how many months it would take to complete this period. For example, if the plan's eligibility period, answered in question 6 a) is expressed as 45 shifts worked, you must calculate how many months it would take the employees to work 45 shifts, based on their regular work schedule.
(See Program Guide Part I, Item 1.5)

Example: Based on the above, if the employees regularly work 4 shifts per week, this would add up to 16 shifts per month. In this case the 45 shifts worked would be completed within the first three (3) months of employment. If, on the other hand, employees regularly work 3 shifts per week, or 12 shifts per month, they would not be eligible for benefits until they would have completed 4 months of employment.

7. **Termination of benefits**
In the case of a disabled employee who has received less than 15 weeks of benefits and is subject to a temporary or permanent separation from employment, for example a layoff, a strike, a lockout, retirement, etc., explain how the payment of benefits would be affected. *(See Program Guide Part I, Item 2.2)*

8. **Extent of coverage**
Indicate if your employees are covered "24 hours a day" i.e. at all times, whether they are at work or not, even if they were injured while working at a second job. In other words, does the coverage your plan provides remain in effect in both "occupational" and "non-occupational" environments?
(See Program Guide Part I, Item 1.8)

9. **Long-term disability plan**
Indicate if your employees would be covered by a long-term disability plan should an illness or disability extend beyond the duration of benefits provided by this short-term disability plan. If you offer a long-term disability plan, indicate the number of months an employee must be back to work before a relapse of that disability would be considered a new disability under this plan. *(This is often found under the titles of "Successive disabilities" or "Recurrent disabilities" in long-term disability plans.)*

10. **Contact person for plan information**
Indicate the name, title, area code and telephone number (extension if applicable), and facsimile (Fax) number of the person in your organization that we should contact regarding any questions about this plan.

Please attach the completed Schedule to your application and send with the required documents to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5

Or facsimile to: (506) 548-7473

If you require assistance to complete this form, please call toll free: **1-800-561-7923**

Schedule B
(Form on page 17)

Steps to follow:

1. Fill out Schedule B if you have a self-insured Weekly Indemnity Plan.
2. You need to fill out one schedule for every plan you have; you may make photocopies of the form.
3. Attach the completed schedule(s) to the Initial Application Form.
4. Do not forget to keep a copy of the completed form for your files.

Human Resources Development Canada | Développement des ressources humaines Canada

SCHEDULE "B"

WEEKLY INDEMNITY PLAN - SELF INSURED

BEFORE COMPLETING, SEE INSTRUCTIONS IN GUIDE.

1. Employer Name:

2. RC or SBRN

3. The description of this plan is found in one of the following documents or in a combination of the following documents:

- ☐ an Administrative Services Only (ASO) insurance contract, provided by: _____
- ☐ a personnel policy bulletin or procedures manual;
- ☐ an employee's handbook;
- ☐ a Board of Directors minute which has been implemented;
- ☐ a memo or document addressed to the employees;
- ☐ a union or association agreement;
- ☐ other, specify _____

4. Date this short-term disability plan came into effect

5. a) Total number of employees covered by this plan ☐ b) Number of non-union employees ☐ c) Number of union employees ☐

d) List union group(s) if applicable:

Name of Union	Local #	Expiry date of Collective Agreement

6. If the plan covers more than one group of employees, are the benefits different for each group?

☐ Yes ☐ No

IF YES, COMPLETE A SEPARATE SCHEDULE "B" FOR EACH GROUP OF EMPLOYEES. Specify the group of employees to which this schedule applies:

_____

7. a) How long must an employee work, from the date of hire, before becoming eligible for benefits?

After completion of _____
(specify: hours, shifts, days or months worked)

b) If the period is expressed in hours, shifts or days, or otherwise, calculate the maximum number of months an employee would have to work, starting from the date of hire, before being eligible for benefits under this plan: ☐

8. a) What is the level of weekly benefits provided under this plan? ☐ % of Salary

b) What is the maximum weekly benefit payable under this plan? $ ☐ dollars ☐ No maximum

c) When calculating the amount of benefits payable under this plan do you include, in the employee's salary, all regular additional earnings such as overtime, bonuses or shift differentials? ☐ Yes ☐ No

9. How long must an employee wait before receiving benefits in the case of:

Accident _____ days, Illness _____ days, Hospitalization _____ days

10. How many weeks of benefits are payable under this plan? ☐

SCHEDULE B (continued)

11. If a separation from employment, for reasons other than illness or injury, occurs while an employee is receiving benefits under your plan, when would payments terminate?

12. Once an employee has returned to work following a period of disability, when will **full** benefits be reinstated:

In the case of a new disability _____

In the case of recurring disability _____

13. If the disability extends beyond the duration of benefits provided under this short-term disability plan, would your employees be covered for benefits under a long-term disability plan?

☐ Yes ☐ No If yes, what is the reinstatement period for recurring disabilities under this long-term plan? _____

14. Are your employees covered 24 hours a day for any illness or injury?

☐ Yes ☐ No If no, explain

15. Are benefits under your plan reduced because of benefits received from:

a) UI ☐ Yes ☐ No

b) Other Sources ☐ Yes ☐ No If yes, specify other sources:

16. Indicate condition(s) under which benefits would not be paid:

☐ Employee not under the care of a doctor.

☐ Employee whose illness or injury is covered by worker's compensation, the Canada or Quebec Pension plans.

☐ Illness or injury is self-inflicted.

☐ Employee whose illness or injury results from riots, wars or participation in disorderly conduct.

☐ Employee is receiving a retirement pension under your pension plan.

☐ Employee whose illness or injury results from committing a criminal offence.

☐ Disability occurs while employee is on leave of absence or on paid vacation.

☐ Employee who has plastic surgery solely for cosmetic purposes (unless attributable to injury or illness).

☐ Other: _____

_____

17. Contact person for plan information.

_____ ( ) _____

Name (Please print) Telephone #

_____ ( ) _____

Title Fax #

NOTE: YOU MUST INCLUDE A COPY OF THE PLAN DOCUMENT WITH YOUR APPLICATION

NAS 5024 (09-94) E

Instructions to complete Schedule B

Self-insured Weekly Indemnity Plans

- **You must complete Schedule B** for each Weekly Indemnity Plan that is self-insured, or for each group of employees if different benefits are provided under this same plan.

1. **Name of the company**
   Enter the name of the company. This will be used to match this schedule to the Initial Application.
2. **RC Number or SBRN**
   Enter the RC number or SBRN to which this schedule applies.
3. **Description of your plan.**
   Indicate the document(s) in which the description of your plan is found.
4. **Effective date**
   Indicate on what date your plan came into effect.
5. **Number of employees covered by this plan**
   a) Enter the number of employees for whom you remit UI premiums and who are covered by this plan.
   b) Indicate how many are non-union.
   c) Indicate how many belong to a union or unions.
   d) List the name of each union group, local number and expiry date of the current collective agreement.
6. **Groups/benefits**
   If more than one group of employees is involved, and you provide different benefits to each group under this plan, answer "yes" and complete a separate Schedule "B" for each group. For instance, the period of benefits could be different for union employees (e.g. 15 weeks) and for office staff (e.g. 26 weeks); or amount of benefits could be 60% for plant workers and 80% for management, etc. Identify the group of employees to which this schedule applies.
7. **Eligibility period**
   a) Indicate the period of time an employee must work before becoming eligible for benefits. This may be expressed in hours, shifts, days, weeks or months worked.
   b) If the answer to question 7 a) is already expressed in months, go to question 8. If it is expressed otherwise, calculate how many months it would take to complete this period. For example, if the plan's eligibility period,

answered in question 7 a) is expressed as 45 shifts worked, you must calculate how many months it would take the employees to work 45 shifts, based on their regular work schedule. *(See Part I, Item 1.5)*

Example: Based on the above, if the employees regularly work 4 shifts per week, this would add up to 16 shifts per month. In this case the 45 shifts worked would be completed within the first three (3) months of employment. If, on the other hand, employees regularly work 3 shifts per week, or 12 shifts per month, they would not be eligible for benefits until they would have completed 4 months of employment.

8. Benefits paid

a) Indicate the level of weekly benefits as a percentage of weekly salary or equivalent.

b) Indicate the maximum dollar amount that the plan will pay in weekly benefits. If there is no maximum, check (3) the "no maximum" box.

c) Indicate whether the employees' salary, as used to calculate the amount of benefits payable under this plan, includes regular additional earnings such as overtime, bonuses or shift differentials.
(See Program Guide Part I, Item 1.4)

9. Waiting period

Indicate the length of time the employee must wait before starting to receive benefits in case of accident, illness or hospitalization. If benefits are payable from the first day of disability, enter "0" or "Nil".
(See Program Guide Part I, Item 1.6)

10. Duration of benefits

Indicate the number of weeks of disability provided by the plan.
(See Program Guide Part I, Item 2.2)

11. Termination of benefits

In the case of a disabled employee who has received less than 15 weeks of benefits and is subject to a temporary or permanent separation from employment, for example a layoff, a strike, a lockout, retirement, etc., explain how the payment of benefits would be affected. *(See Program Guide Part I, Item 2.2)*

12. Reinstatement of benefits

Enter the number of days, weeks or months an employee must be back at work following a disability before full benefits are reinstated.

a) new disability (unrelated to previous disability)

b) recurring disability (relapse of a previous disability)
(See Program Guide Part I, Item 2.3)

13. Long-term disability

If you offer a long-term disability plan, indicate the number of months an employee must be back to work before a relapse of that disability would be considered a new disability under this plan. (*This is often found under the titles of "Successive disabilities" or "Recurrent disabilities" in long-term disability plans.*)

14. Extent of coverage

Indicate if your employees are covered "24 hours a day" i.e. at all times, whether they are at work or not, even if they were injured while working at a second job. In other words, does the coverage your plan provides remain in effect in both "occupational" and "non-occupational" environments? *(See Program Guide Part I, Section 1.8)*

15. Integration or reduction of benefits

a) Indicate whether benefits received from UI would be deducted from benefits paid under this plan.

b) Indicate whether benefits from other sources, for example private insurance, third party liability, etc., are deducted from benefits paid under this plan. If yes, describe "other sources".

16. Conditions under which benefits need not be paid

Check off limitations found in your plan. If your plan contains other limitations not listed here, check "other" and describe the limitation. *(See Program Guide Part I, Item 1.9)*

17. Contact person

Indicate the name, title, area code and telephone number (extension if applicable), and facsimile (Fax) number of the person in your organization that we should contact regarding any questions about this plan.

Please attach the completed Schedule to your application and send with the required documents to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick E2A 4T5

Or facsimile to: (506) 548-7473

If you require assistance to complete this form, please call toll free: **1-800-561-7923**

Schedule C
(Form on page 23)

Steps to follow:

1. Fill out Schedule C if you have a Paid Sick Leave Plan.
2. You need to fill out one schedule for every plan you have; you may make photocopies of the form.
3. Attach the completed schedule(s) to the Initial Application Form.
4. Do not forget to keep a copy of the completed form for your files.

SCHEDULE "C"

CUMULATIVE PAID SICK LEAVE PLAN

BEFORE COMPLETING, SEE INSTRUCTIONS IN GUIDE.

1. Employer Name:

2. RC or SBRN:

3. The description of this plan is found in one of the following documents or in a combination of the following documents:

- ☐ a personnel policy bulletin or procedures manual;
- ☐ an employee's handbook;
- ☐ a Board of Directors minute which has been implemented;
- ☐ a memo or document addressed to the employees;
- ☐ a union or association agreement;
- ☐ other, specify _____

4. Date this plan came into effect

5. a) Total number of employees covered by this plan ☐ b) Number of non-union employees ☐ c) Number of union employees ☐

d) List union group(s) if applicable:

Name of Union	Local #	Expiry date of Collective Agreement

6. If the plan covers more than one group of employees, are the benefits different for each group?

☐ Yes ☐ No

IF YES, COMPLETE A SEPARATE SCHEDULE "C" FOR EACH GROUP OF EMPLOYEES. Specify the group of employees to which this schedule applies:

7. a) From the date of hire, when would an employee start accumulating days of paid sick leave?

After completion of _____ (specify: hours, shifts, days or months worked)

If the period is expressed in hours, shifts or days, calculate the maximum number of months an employee would have to work, from the date of hire, before starting to accumulate paid sick leave credits: ☐

b) From the date of hire, when would an employee be eligible to start using these days of paid sick leave?

After completion of _____ (specify: hours, shifts, days or months worked)

If the period is expressed in hours, shifts or days, calculate the maximum number of months an employee would have to work, from the date of hire, before being eligible to start using sick leave credits: ☐

8. How long must an employee wait before receiving benefits in the case of:

Accident ____ days, Illness ____ days, Hospitalization ____ days

9. What is the level of benefits provided under this plan? ☐ % of Salary

CONTINUED ON REVERSE

SCHEDULE C (continued)

10. a) The number of days of paid sick leave that can be accumulated for each full month of active employment is:

_____ to a maximum of _____ days.

b) Is there a certain number of days per month that an employee must work in order to be credited with paid sick leave?

☐ Yes ☐ No If yes, indicate the number of days ☐

c) Can days of paid sick leave be accumulated on a pro rata basis?

☐ Yes ☐ No If yes, explain how the calculation is made:

11. Does your Paid Sick Leave plan allow for the use of days for reasons other than the employee's illness or disability?

☐ Yes ☐ No If yes specify: a) Number of days per year ☐

b) Reasons

12. If a separation from employment, for reasons other than illness or injury, occurs while an employee is receiving benefits under your plan, when would payments terminate?

13. Are your employees covered 24 hours a day for any illness or injury?

☐ Yes ☐ No If no, explain

14. Are benefits under your plan reduced because of benefits received from:

a) UI ☐ Yes ☐ No

b) Other Sources ☐ Yes ☐ No If yes, specify other sources: _____

15. Indicate condition(s) under which benefits would not be paid:

☐ Employee not under the care of a doctor.

☐ Employee whose illness or injury is covered by worker's compensation, the Canada or Quebec Pension plans.

☐ Illness or injury is self-inflicted.

☐ Employee whose illness or injury results from riots, wars or participation in disorderly conduct.

☐ Employee is receiving a retirement pension under your pension plan.

☐ Employee whose illness or injury results from committing a criminal offence.

☐ Disability occurs while employee is on leave of absence or on paid vacation.

☐ Employee who has plastic surgery solely for cosmetic purposes (unless attributable to injury or illness).

☐ Other: _____

16. Contact person for plan information.

_____ Name (Please print)

( ) _____ Telephone #

_____ Title

( ) _____ Fax #

NOTE: YOU MUST INCLUDE A COPY OF THE PLAN DOCUMENT WITH YOUR APPLICATION

Instructions to complete Schedule C

Cumulative Paid Sick Leave Plans

- **You must complete Schedule C** for each Cumulative Paid Sick Leave Plan or for each group of employees if different benefits are provided under this same plan.

1. **Name of the company**
   Enter the name of the company. This will be used to match this schedule to the Initial Application.
2. **RC Number or SBRN**
   Enter the RC number or SBRN to which this schedule applies.
3. **Plan Description**
   Indicate the document(s) in which the description of your plan is found.
4. **Effective Date**
   Indicate on what date your plan came into effect.
5. **Number of employees covered by this plan**
   a) Enter the number of employees for whom you remit UI premiums and who are covered by this plan.
   b) Indicate how many are non-union.
   c) Indicate how many belong to a union or unions.
   d) List the name of each union group, local number and expiry date of the current collective agreement.
6. **Groups/benefits**
   If more than one group of employees is involved, and you provide different benefits to each group under this plan, answer "yes" and complete a separate Schedule "C" for each group. For instance, the maximum accumulation could be 75 days for union employees and 125 days for office employees. Identify the group of employees to which this schedule applies.
7. **Eligibility period**
   a) Indicate the length of time an employee must work before starting to accumulate days of paid sick leave;

   If this period is already expressed in months go to question 7 b).

   If this period is expressed in hours, shifts or days, calculate how many months it would take an employee to complete this period.

Example: If the plan's eligibility period, answered in question 7 a) is expressed as 45 shifts worked, you must calculate how many months it would take the employees to work 45 shifts, based on their regular work schedule. If the employees regularly work 4 shifts per week, this would add up to 16 shifts per month. In this case the 45 shifts worked would be completed within the first three (3) months of employment. If, on the other hand, employees regularly work 3 shifts per week, or 12 shifts per month, they would not be eligible for benefits until they would have completed 4 months of employment.

b) Indicate the length of time an employee must work before being able to use days of paid sick leave.

If this period is already expressed in months, go to question 8.

If this period is expressed in hours, shifts or days, calculate how many months it would take an employee to complete this period.
(See Program Guide Part I, Item 1.5)

8. Waiting period
Indicate the length of time the employee must wait before starting to receive benefits in case of accident, illness or hospitalization.

9. Benefits paid
Indicate the level of weekly benefits as a percentage of weekly salary or equivalent.

10. Rate of accumulation of paid sick leave credits

a) Indicate the number of days of sick leave credited for each month of active employment. This should be shown as 1, 1.5 or 2 etc.
Give the maximum number of days that can be accumulated.
If there is no maximum, indicate "N/A".

b) Some plans may require that employees work at least a certain number of days per month in order to earn sick leave credits. If this is the case, indicate the minimum number of days that must be worked before a credit will be made.

c) Employees who regularly work on a part-time basis may be allowed to accumulate sick leave credits on a pro-rata basis. If so, please indicate how you calculate the amounts credited.
(See Program Guide Part I, Item 3.2)

11. Other use of sick leave credits
Indicate whether you allow your employees to use sick leave credits for reasons other than illness or disability. If yes, indicate how many days of paid sick leave per year can be used for other reasons, specifying the reasons.
(See Program Guide Part I, Item 3.2)

12. Termination of benefits

In the case of a disabled employee who has either received less than 75 days of paid sick leave or the total accumulation of his paid sick leave, whichever occurs first, and is subject to a temporary or permanent separation from employment, for example a layoff, a strike, a lockout, retirement, etc., explain how the payment of benefits would be affected. *(See Program Guide Part I, Item 3.3)*

13. Extent of coverage

Indicate if your employees are covered 24 hours a day, i.e. at all times, whether they are at work or not, even if they were injured while working at a second job. In other words, does the coverage your plan provides remain in effect in both "occupational" and "non-occupational" environments?

14. Integration or reduction of benefits

a) Indicate whether benefits received from UI would be deducted from benefits paid under this plan.

b) Indicate whether benefits from other sources, for example private insurance, third party liability, etc., are deducted from benefits paid under this plan. If yes, describe "other sources".
(See Program Guide Part I, Item 1.7)

15. Conditions under which benefits need not be paid

Check off limitations found in your plan. If your plan contains other limitations not listed here, check "other" and describe the limitation.
(See Program Guide Part I, Item 1.9)

16. Contact person

Indicate the name, title, area code and telephone number (extension if applicable), and facsimile (Fax) number of the person in your organization that we should contact regarding any questions about this plan.

Please attach the completed Schedule to your application and send with the required documents to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5

Or facsimile to: (506) 548-7473

If you require assistance to complete this form,
please call toll free: **1-800-561-7923**

Schedule D
(Form on page 29)

Steps to follow:

1. A Schedule D must accompany each Initial Application submitted. Please check your answer to question 8 on the initial application.
2. You may make photocopies of the form.
3. Attach the completed schedule to the Initial Application Form.
4 Do not forget to keep a copy of the completed form for your files.

SCHEDULE "D"

RETURNING 5/12 OF THE PREMIUM REDUCTION TO EMPLOYEES

Where no **signed mutual agreement** exists on the method used, the employer may decide how to return the employees' portion of the reduction. In this case, however, the employer must ensure that:

- the benefit will be provided in the year of reduction or within the first four months of the following year;
- the benefit will be accessible to all the employees covered by the qualifying plan(s);
- the benefit will be equal in value to at least 5/12 of the reduction;
- the benefit is a new or upgraded benefit that did not exist prior to the application for a premium reduction.

BEFORE COMPLETING, SEE INSTRUCTIONS IN GUIDE.

1. Employer Name:	2. RC or SBRN:

The following will be used to assess the method used as well as its value.

3. Describe the benefit provided:

4. a) Is the benefit an acquired right through a collective agreement or otherwise?
☐ Yes ☐ No

b) Was it in existence prior to the initial application?
☐ Yes ☐ No

5. Is this benefit offered to all the employees covered by the plan(s) being registered?
☐ Yes ☐ No

If no, what group of employees do not have access to this benefit?

6. What will be the cost, or projected cost, of this benefit per employee?

7. When will this benefit be provided?

DECLARATION

I declare that the information given in this schedule is true and accurate. I am aware that there are penalties for false statements

Signature of Authorized Officer

Date

Title

Instructions to complete Schedule D

Returning 5/12 of the savings from the premium reduction to employees

If a written agreement exists between employer and employees concerning the method of returning their portion of the premium reduction, a copy of this agreement should accompany the Initial Application. If such a document does not exist, the employer must complete **Schedule D** and send it with his application.

The UI Act specifies that the employer must return the employee portion of a premium reduction to all employees for whom the reduced rate applies. Since both employers and employees pay UI premiums in a ratio of 7/12 and 5/12 respectively, employees must receive 5/12 of the savings. **Please refer to Part I, Item 1.2 of Program Guide for information on calculating the employee portion of the premium reduction, and for a description of arrangements that would be acceptable to the Department.**

1. **Name of the company**
   Enter the name of the company. This will be used to match this schedule to the Initial Application.

2. **RC Number or SBRN**
   Enter the RC number or SBRN to which this schedule applies.

3. **Description of benefit provided**
   Provide a brief description of the benefit(s) that you will provide to your employees as a means of returning the portion of the premium reduction that belongs to them.

4. **Employee's right to the benefit.**
   a) Indicate whether or not this benefit is contained in a collective agreement.

   b) Indicate whether this is a new benefit or one already in existence before you applied for a premium reduction.

5. **Groups of employees who have access to the benefit**
   Indicate whether this benefit is available to all the employees covered under the plan being registered. If not, indicate what groups of employees would not have access to it.

6. **Cost of benefit**
   Please indicate the actual cost of this benefit, per employee, per year. If the actual cost is not yet known, indicate the projected cost.

7. Effective date of benefit

Indicate the date on which the benefit will be made available to your employees.

This schedule must be signed by an authorized representative of the company.

Please attach the completed Schedule D to your application and send with the required documents to:

Human Resources Development Canada
Premium Reduction Program
Nicolas Denys Building
P.O. Box 11000
Bathurst, New Brunswick
E2A 4T5

Or facsimile to: (506) 548-7473

If you require assistance to complete this form, please call toll free: **1-800-561-7923**